Your Facility

How to Create a Compliance Plan
“Iron Rules” of Medicare

Rule 1  Just because you have a code for it, doesn’t mean it’s covered.

Rule 2  Just because it’s covered, doesn’t mean you can bill for it.

Rule 3  Just because you can bill for it, doesn’t mean that’s what you’ll be paid.

Rule 4  Just because you were paid, doesn’t mean you get to keep it.

Rule 5  Just because you were paid once, doesn’t mean you’ll be paid again.
“Iron Rules” of Medicare

Rule 6  Just because you were paid in State X, doesn’t mean you’ll be paid in State Y.

Rule 7  You can never truly know what the rules are

Rule 8  Violating the rules can land you in the slammer

Rule 9  There is always someone who doesn’t get the message

Rule 10  There is always someone who refuses to believe the message.
In the 1980’s the Office of Inspector General of HHS made three main recommendations to Congress for addressing the impending insolvency of the Part A Medicare Trust Funds:

- Expand funding requirement of employers;
- Address coverage and payment policies;
- Increase enforcement against fraud and abuse

By 1994, the last recommendation had surfaced as a key means of ensuring the fiscal integrity of the Medicare Program.
One Interpretation of the Civil False Claims Act

You knowingly make a false claim if you fail to make an inquiry about the accuracy of the claim which is reasonable and prudent under the circumstances.

Organizational Sentencing Guidelines define “willful ignorance” as a failure to investigate the possible occurrence of unlawful conduct despite the knowledge of circumstances that would lead a reasonable person to investigate whether unlawful conduct has occurred.
DHHS 1999 Audit

Recommendations:

• Update ability to assure adequate oversight of questionable billing practices

• Enhance pre-payment and post-payment computer controls

• Expand provider training regarding documentation and proper coding

• Encourage providers to adopt compliance plans
Medicare Program Oversight

- Medicare Contractors (Fiscal Intermediary and Carrier) a Program Integrity Units
- Medicaid Fraud Control Units
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes the:
  - Medicare Integrity Program (MIP)
  - Improve HCFA’s ability to deter fraud and abuse in the Medicare Program
  - Grant HCFA contracting authority and a stable, long-term funding mechanism for MIP activities
  - Program Safeguard Contractors
  - Program integrity and enhanced data capabilities
When is a Compliance Program “Ineffective”? 

- An individual within high-level personnel is involved in the violation;

- A person within high-level personnel in the culpable unit of the organization is involved in violation; or

- A person involved in administering the compliance program is involved in the violation

U.S. Sentencing Guidelines §8C2.5(f)
Assessing Effectiveness of a Compliance Program

Evaluating how a compliance program performs during the provider’s day-to-day operations becomes the critical indicator.

Evaluation may be accomplished through techniques such as:

- Employee surveys and feedback
- Management assessments
- Periodic review of benchmarks established for audits
- Investigations
- Disciplinary action
- Overpayments

Evaluate all elements of the compliance program, including policies, training, practices, and compliance personnel.

OIG Model Guidance

An effective program should incorporate thorough monitoring of its implementation and ongoing evaluation process.
Compliance Program Process

Assess: Compliance officer, compliance committee, staff, management

Plan: Central compliance office, business unit/site compliance committees

Implement: Compliance manuals, intranet, delegated responsibilities

Monitor: Risk assessments, compliance indicators, periodic reports
Compliance Program Process

- Key Job Responsibilities
- Risk Assessment Matrices
- OIG Annual Work Plan Comparison Table
- Review Forms and Action Plans
- Compliance Education and Training Matrices
Benefits of a Compliance Program

Well-designed compliance program can:

- Expedite proper payment of claims
- Minimize billing mistakes
- Reduce chances of any audit by CMS or the OIG
- Avoid conflict with the self-referral and anti-kickback statutes
- Demonstrate that the physician practice is making additional good faith efforts to submit claims appropriately.
- Also, increased accuracy of documentation should assist in enhancing patient care
Impact of a Compliance Program for Billing on Internal Medicine Faculty’s Documentation Practices and Productivity

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• **Method:** Site Profile, Payer Profile, Data Collection, Intervention

• **Results:** Operational Implications, Keys to Success, Study Limitations

**Website:** http://www.academicmedicine.org:80/cgi/content/full/76/3